

### WHAT MEN WANT: BEING A GOOD DOCTOR TO KIWI BLOKES

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Psychologists know that there are more and stronger similarities between the genders than differences between them, but traditional culture does impose distinct pressures on men, which will affect the thinking, feelings and behaviour of individuals according to how strongly they subscribe to those masculine norms and according to the social settings they find themselves in. As part of cultural awareness for effective practice, it is important to have some sense of the particular needs of men... whilst bearing in mind that men's understandings of masculinity are not homogeneous, they are changing all the time and therefore differ by age cohort, and that many women will have the same needs.

The 'tips' and quotations you are about to read draw from research interviews with 27 New Zealand men with cancer domiciled in the Horowhenua, Otaki, Whanganui and South Taranaki regions – which have generally poorer income and health statistics – conducted in 2011 for the Cancer Society of New Zealand, Movember, and Massey University. My aim is to help you *feel, envisage, and therefore remember* what these men were experiencing and what they needed from their doctors by providing you with direct quotations snippets from their stories.

To prepare for reading the 'tips' I provide a little background from the literature: (1) What those traditional masculine norms are (this summary is confined to Anglo cultural traditions, but there are some important similarities with other cultural traditions); (2) What barriers men face in utilising health services; (3) The dilemma of being masculine and needing to 'seek help'; and (4) The relational/emotional isolation suffered by many men.

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### *Background literature on men and health*

#### ***Traditional masculine norms***

Socialisation to cultural norms is hugely impacting in the forming of a person's identity and psychological responses and needs. Four traditional masculine normative themes were set out by David and Brannon (1976):

1. No sissy stuff: Avoid femininity (e.g. help seeking, empathy), conceal emotions
2. Be a big wheel: Breadwinner, admired and respected, powerful, strong, competitive, instrumental orientation
3. Be a sturdy oak: Toughness, 'male machine', independence, self-confidence, self-reliance
4. Give 'em hell: Take risks, face danger, demonstrate bravado, adventure, aggression

These themes can be reduced to three (Thompson & Pleck, 1986): status (achieve status and respect); toughness (physical, mental, emotional, including self-reliance) and anti-femininity . Burke (2002) summarises the norms again (p.41): "Men suffer under a code of masculinity requiring them to be aggressive, dominant, achievement oriented, competitive, rigidly self-sufficient, adventure-seeking, willing to take risks, emotionally restrictive, and avoidant of all things feminine (Levant & Pollack, 1995; Maier, 1999; Mooney, 1995)." Men are rewarded at work for such behaviour – being competitive and 'in control' of their emotions, and appearing invulnerable by not seeking help. One psychological theory holds that 'gender role strain' is felt in accordance with how far a man perceives his performance to fall short of the gendered norm – he feels shame. Given that the normative ideals for men are unachievable, men are threatened with failure and consequent shame constantly (Burke, 2002) with implications for their behaviour and mental health.

Note that at the top of the list of masculine norms is anti-femininity. Brannon and colleagues saw this item as the most central and important in the masculine identity (Brannon & Juni, 1984). In the context of health, this prohibition from behaving in any way that may be considered feminine has enormous implications since critically important behaviours such as caring for oneself and seeking help can be viewed as feminine behaviours, and the health system is staffed disproportionately by women.

Breadwinner status also has implications in the context of disabling illness. Axelrod (2001) suggests that the way that men feel about their work is characterised by a unique intensity because mastery at work is associated with securing a sense of masculinity. It is necessary to constantly prove and re-prove masculine status by constructive productivity and achievement. Thus the meaning of work is tied closely to a man's sense of masculinity, which is jeopardised in the face of chronic illness or disability.

Maintaining emotional control is a common thread in the Brannon list, and is also potentially threatened by chronic or serious illness. One aspect of maintaining emotional control is concealing vulnerability, which involves suppressing the expression of intimate feelings in conversation with others. Butera (2008) discusses the phenomenon of 'mateship' between men in Australian culture and how communication is maintained on a very superficial level which suppresses emotional intimacy, thus creating a relationship which is in fact the very antithesis of friendship. The concealment of vulnerability is necessary, however, if people consider themselves in competition with each other and likely to be hurt by confidants, as is the expectation between men according to masculine ideology. In Butera's study, the only people with whom her older cohort of participants (64-87 years of age) felt safe to communicate intimate feelings were their wives. All 15 of Butera's older cohort described their wife as their best friend and closest confidante and the only person with whom they would share deep feelings and thoughts. This contrasted with the practice described by the younger cohort (men in their 20's). Men from both the older cohort and the middle aged group (in their 40's) demonstrated how expressing emotion was regarded as improper e.g. by apologising when some emotion slipped out in the interview. Butera found that men of all three cohorts showed their support for each other in practical ways, although, again in accordance with a need to avoid displaying vulnerability, it was considered more appropriate to offer, rather than ask for, such support.

Is Brannon's description of masculine ideals now dated and irrelevant? After the All Blacks won the Rugby World Cup in October 2011, team captain, Richie McCaw, honoured the courage and determination of his team, declaring, 'It's what's under your left tit that counts'. Commentators honoured players for how they 'put their bodies on the line' and 'left it all on the paddock', glorifying their willingness to risk their health for the game. We continue to honour sportspeople for the 'commitment' they show in ignoring pain and injury in order to perform. After the last Rugby World Cup game, against France, allegations emerged that McCaw had heavily kned a key French player in the face, breaking his nose and forcing him off the field, and that a French player had attempted to eye-gouge McCaw – possibly in retaliation. Yet the main French reporter commenting on McCaw's allegation maintained that he is 'a gentleman' and his word on the eye-gouging was not to be questioned. In our sports-mad country (at time of writing we have just achieved more medals per capita than any other in the London Olympics) are these sorts of comments telling us that we still subscribe quite strongly to masculine norms?

Butera (2008)'s recent qualitative study of 'mateship' in Australia showed that some of the prescriptions of traditional masculine ideology were fading for younger cohorts, but not for the retired cohort of men. She showed that the younger generation of men (in their 20's) are

more open to emotional disclosure (i.e. are more willing to display vulnerability) and expect more emotional support from their 'mates' than men in their 40's or men of retirement age. The older cohort (64-87 years of age) retained traditional views: They were guarded in self disclosure (except to their wives) and expected to give and receive support of a purely practical – not emotional – nature from their mates. Middle aged men were caught amidst changing attitudes, with some feeling comfortable with traditional levels of relating, and others expressing frustration or disappointment that their peers might avoid or reject their overtures at a deeper emotional exchange.

### ***Barriers to health care utilisation***

Why do men not utilise the health system more? Do they even care about their health? Ridiculous though it may seem, that question is genuine in the minds of many health professionals (e.g. refer Mitchell & Horn, 2006, below). I now set out some of the reasons that men do not use services as much as women. They include their less adequate knowledge of health issues and the health system, their health beliefs, and the appropriateness of services for men. Note how the influence of masculine norms threads through these reasons in complex ways.

A report prepared for the Wellington Division of the New Zealand Cancer Society on Men's Health (McKinlay et al., 2005) attempted to define men's concepts of health better and the barriers to men making better use of primary services. It collected data from focus groups comprising primary health professionals (GPs and practice nurses) and men, with the professional groups re-convening to consider the men's comments. It found barriers of varying natures:

- Systems and structural issues i.e. timing issues, convenience, and gender appropriateness of services e.g. the services don't fit with men's working hours, information re options are wanting, the practice environment is too feminine, the cost of services, waiting times, insufficient time available at appointments, needing a partner-type relationship/discussion between man and GP
- Men's attitudes or lack of knowledge
- Health professionals' attitudes and beliefs i.e. negative attitudes subverted attempts to connect with men about their health e.g. there was professional acceptance that women live longer, men were considered disorganised and not willing to take responsibility for their health, they were considered uninterested in addressing risky lifestyle factors (for women professionals, they were considered hopeless cases who will not change, and for male professionals, risk taking may be condoned as innate or even commended), it was felt that men are neglectful of their health or will not face issues directly because they are fearful of appearing weak or becoming vulnerable, that they will deny problems (e.g. drinking behaviour), that they are reluctant to talk about certain matters (feelings, mental health, sexual matters, i.e. 'personal' issues) and that seeing only an afterhours GPs (rather than a regular GP) makes it even more likely that they won't state their fears. It was felt that health professionals were not altogether comfortable with health promotion roles or 'touting' by sending reminders, and that they lacked confidence in some screening procedures or health promotion, and were not convinced that reminders are helpful (i.e.

that they were disempowering of men's responsibility). On the positive side, it was felt that although men were uncomfortable talking about some issues, they were happier with the collection of objective data, and liked the WOF (warrant of fitness i.e. mechanical) analogy. It was also recognised that men can be keen to talk about their health and to understand checks better (e.g. blood pressure).

- Societal indifference to men's health inequity
- Issues affecting particular groups e.g. Māori could have a fatalistic view of their lifespan because their forbears had had short lives, and therefore they may not curb harmful behaviours, or they may not be able to afford prompt consultation.

The report noted that men have higher mortality rates particularly due to cancer. It also noted that, "It has been said...that the male gender culture in many aspects is pathogenic rather than protective of health, and the majority of negative aspects can be categorised under the rubric of 'lifestyle choices and occupation'" (McKinlay, et al., 2005, p.7) i.e. self harming behaviours involving alcohol, diet, suicide, and also employment in more hazardous occupations, problems controlling anger, and risk taking, including unlawful behaviour. Summarising American literature, Stanton and Courtenay (2004) assert that men with more traditionally masculine attitudes adopt more maladaptive coping strategies and risky behaviours and are at even greater risk of death. They give an example of bragging, "I haven't been to the doctor in years" (p.109) as part of proving manhood - as if this was an honourable thing and a defining characteristic of a real man.

The relationship of masculinity to the motivation of men to utilise the health system is complex and leaves a number of opportunities for effective connection. A New Zealand focus group study (six occupational health nurses) conducted by Mitchell and Horn (2006) discussed this complexity. After initially expressing frustration at an apparent lack of interest by men in their health, participants reflected that men were very aware of their health needs and prepared to discuss them in depth given a supportive environment, and were also very aware of the health needs of their colleagues. However, they felt that men experience health "as a complex dynamic between their health status, their continuing employment, their role in family support and, ultimately, their self-esteem and self worth. Further, any threat to their health – real or imagined – carried an implicit threat to their employment, their family and their view of themselves. Health assessment was seen as one such threat." Mitchell and Horn (2006, p. 16). It was felt that men struggle with and are stressed by the need to manage these tensions, and that if the environment is not sensitive and supportive to them in this, then they may manage their stress in ways that are in fact hazardous to their health (e.g. risk taking recreation, excess alcohol use).

This finding of the complexity of pressures upon men in making choices about engaging with the health system shows a much more sympathetic understanding of masculinity, and is much more useful to the consideration of how health interventions might be made successful. The process that participants went through leading to this conclusion also gives a sense of the frustration that professionals feel about the way men and the present health system interact and the health outcomes that men suffer, and is also an illustration of how that frustration can

turn from blaming to understanding when sympathetic thought is encouraged. A professional attitude that is blaming of men must surely be a most – *the* most – significant barrier to progressing men's health, since it is the professionals who determine what form the services will take. I return now to discuss some of the other barriers.

Men are not socialised into the health culture from an early age and feel less confident with the health system, seeing it as a women's domain since the visits they had as a child tended to be with a female caregiver (McKinley, 2005). Women have the opportunity of building a relationship with their GP through regular attendances for contraception, maternity and cervical screening checks. Men lack experience at talking about their bodies, which makes communication with doctors and nurses uncomfortable, whereas women have the experience of regular attendance due to getting contraception prescriptions, childbearing and raising checks, more developed screening programmes (White, 2001). Citing a British study, McKinley (2005) says that men are inhibited from consulting GPs due to a lack of understanding about the process of making appointments, inconvenient hours, being unhappy to wait for appointments, feeling uncomfortable in the predominantly female environment, a fear of being judged, a lack of confidence in confidentiality, and a lack of language ability for discussing their bodies. Summarising other literature findings, McKinley says that men needed an obvious physical symptom to prompt getting a consultation, that they appeared inhibited from fully describing the extent of their health concerns especially if they were not physical, that they bring fewer problems to a consultation and have shorter time in consultation, that they focus on problems that could influence work, and that they fear physical contact during consultation. Again, the influences of masculine norms and socialised roles are suggested.

Men have been found 'surprisingly uninformed' about basic health issues, including the risk factors associated with particular diseases (Courtenay, 2005, citing the American Medical Association's conclusion based on two national surveys, p.35). Lack of such knowledge has been associated with underuse of health care and unhealthy behaviours (Courtenay, 2000c). Men may not compensate for their lack of knowledge by seeking more help – on the contrary, men are often reluctant to seek medical help, thereby appearing vulnerable, and are also more reserved and embarrassed about discussing particular issues, especially those that relate to social, psychological or genital problems (Courtenay, 2005; McKinley, 2005). Male ignorance and 'attitude' were detailed as a barrier by the focus groups (McKinlay, et al., 2005): men feel invincible until they turn 30; they need something 'really wrong' with them before they will go to their GP (i.e. tangible interference with work etc. not just feeling unwell) or they need an administrative purpose (e.g. insurance certificate); they lack health knowledge; they need prompting by a partner or the illness of a friend to go to their GP; or they fail to have their own GP. Much of this list can be boiled down to a lack of health and health system understanding, although pressures from masculine norms are also at play.

Men rate their health better than women (despite the facts to the contrary) and do not self-report accurately. Men report fewer symptoms of physical and mental illness, are less likely to notice signs of illness and to consider themselves at risk of illness (e.g. of AIDS or skin cancer), and underestimate risks associated with dangerous activities (Courtenay, 2003). U.S.

literature shows that boys are socialised not to express their pain and to deny it, and girls to be openly emotional, and that adults often respond more to girls' pain. Women's coping strategies for pain involve emotional expression and men's often involve denial of pain, suppression of emotion around it, and taking action instead (Sabo, 2005). Parents are less concerned about the safety of sons, and are less likely to extend to them warmth and nurturance. Boys are talked to less about sadness and more about anger. They are considered less vulnerable and handled roughly, physically punished more, encouraged in activities that distance them from their parents and discouraged from seeking help. Consequently they have greater difficulty in identifying and expressing emotions and physical needs as men. Men also believe less strongly that they have control over their future health, including that their own actions contribute to it (Courtenay, 2003).

Being less informed about health issues, and less aware of their vulnerability, not only are men disadvantaged in identifying symptoms as illness-related, but they may also tend towards a reactive rather than proactive approach to illness, and think that a doctor will not be able to help their symptom (McKinley, 2005). Furthermore men may deliberately undertake risky behaviour in order to prove their manhood. They are sensitive to peer pressure in their need to avoid losing status among men, which requires the appearance of invulnerability and so militates against seeking help with health matters (McKinley, 2005). Obviously, there is less reason to go to the doctor if you do not perceive a threat to your health or if you feel that your actions will make no difference to your state of health. Again, the influence of a combination of ignorance and masculine norms is suggested.

It is to be expected that men may require a different approach to health services given their different knowledge and beliefs about health, the constraints of masculine norms on their behaviour, and that their daily work schedule can be more rigid than that of many women who may work fewer hours in paid employment. However, there is limited recognition of the different needs of men in the way health services are delivered, and masculine norms influencing the approach of GPs can be part of the problem.

The literature shows that physicians give men less time and briefer explanations during consultations. Men are less likely to be warned by physicians about changing unhealthy lifestyle and are less likely to be taught self-examination. They are under-diagnosed for mental health problems that are associated with women (e.g. depression) which may contribute to their much higher suicide rate (Stanton & Courtenay, 2004). It also indicates that male professionals find it as threatening to delve beneath the superficial as their male patients do, and that medical training is imbued with macho culture (independence, leadership, arrogance), which is limiting to conversations of a 'personal' nature (McKinley, 2005). In this sense, masculine norms at work at the service delivery end are restricting good communication to men about their health. What is needed is the exact opposite approach, where doctors explicitly acknowledge difficulties men may be having expressing health concerns, assume symptoms, and ask for confirmation rather than waiting for men to report them, making a point of normalising the man's experience (Courtenay, 2005). Mitchell and Horn (2006) recommend the development of specific skills for engaging male patients,

including the use of terms like Warrant of Fitness rather than 'health assessment', and an assertive and direct no-nonsense communication style.

Despite these problems, the literature also shows that men generally like and trust their doctors. However, they like to work in a model of partnership - shared power - in decision making (McKinlay, et al., 2005; McKinley, 2005). Being in control, or at least partially so, is a basic too the ideology of traditional masculinity described earlier. This sets the scene for conflict and breakdown where both doctor and patient want control of the consultation.

The unavailability of health services during non-working hours is recognised internationally as a factor that can compound any reluctance that men have to use services (Stanton & Courtenay, 2004). This and other 'systems and structural issues' that can create barriers for men were listed by McKinlay and others (2005)(above). Important among them are the convenience of services to fit in with men's work schedules, including organisation around waiting times, and the gender appropriateness of the atmosphere at the consultation rooms. Mitchell and Horn (2006) noted how the presence of health services in the workplace assists accessibility and that they are best supported by a workplace culture that sees health services as an opportunity rather than a cost. Another delivery mechanism that could be used in flexible ways and various settings is the role of practice nurse.

In sum, barriers to men's utilisation of health services come from both sides of the service delivery fence: from the attitudes and knowledge that men bring to health, and from the appropriateness of services to their needs. Gendered attitudes, biases and expectations seem to impact both sides. And it must be remembered that barriers are exacerbated by ethnic difference and socio-economic deprivation (McKinley, 2005). This is for obvious reasons around the cultural competence of services and their accessibility and affordability to people of limited education and/or income, as well as for less obvious reasons such fatalistic views associated with intergenerational experience of shorter lifespan (McKinlay, et al., 2005).

### ***Help-seeking***

According to a review of the literature by Addis and Mahalik (2003), the finding that men seek professional help less frequently than women is strikingly consistent in research covering medical, mental health, and substance abuse contexts, and regarding different ages, nationalities and ethnic and racial backgrounds. This reluctance manifests as delay – or a series of delays – in seeking help with health matters, and in failing to report symptoms.

There is a mounting body of research indicating that traditional masculine beliefs were significant in influencing the health risk appraisal and health seeking behaviour of men when they are ill (Galdas, Cheater, & Marshall, 2005): "...[M]en are not permitted to be expressive in their illness behaviour...or are 'unable' because of the construction of traditional masculinity, or an effort to conform to a socially prescribed male role where weakness and need for help are not believed to be masculine..." (p.621). Findings noted from studies using various methodologies included men: ignoring symptoms; hoping symptoms would go away or cure themselves (like a cold); hoping that they could fight symptoms off; not considering symptoms sufficiently serious to warrant seeing a doctor – who should be



consulted only when 'really ill'; rationalising or attempting to normalise symptoms (even despite severe chest pain); having a 'wait and see' attitude; feeling that seeking help was not an obvious solution / regarding seeking expert advice as strange; feeling discomfort and unfamiliarity with confiding in a GP; having feelings of vulnerability / embarrassment; having a reluctance to or fear of appearing foolish, weak or not masculine, because it was considered important to be controlled and silent about one's emotional life; or having masculine feelings of 'invincibility' which militated against seeking help. Galdas et al. note that several authors suggest that these attitudes and behaviours are linked to traditional norms of masculinity, associating more awareness and health concern with femininity.

In the context of psychotherapy, Good and Brooks (2005) argue that men are reluctant clients because of: stereotypes that the male client is weak; conflicts between the male role and the client role; a traditional male sense that there is a collusion among women and therapists against men; and the lack of recognition of men's particular needs in therapy. In the light of such concerns about appearing weak, it is interesting and pleasing to see the work of rugby coach and former All Black great Sir John Kirwan in normalising depression and the seeking of treatment. Note how the approach that Sir John uses on his website (<http://www.depression.org.nz>) is tailored to masculine culture: He explains that depression is "not a weakness, its just an illness" and suggests making "a plan to get through" with emphasis on physical activity and problem solving – all strengths lauded by traditional masculine ideology. He also normalises the experience in his own life story, *All Blacks don't cry* (North Shore NZ Penguin). All of this protects a man with traditional masculine values from the 'gender role strain' and shame of feeling that he is a failure and weak, and gives him practical things he can do to take control of his situation and work his way out of it, with hope and dignity intact.

### ***Social isolation***

A key factor underlying both physical and mental health – and of particular note in relation to men - is the availability of personal support from family, friends, and work or community networks, and particularly from spouses/partners. A recent large meta-analysis (Holt-Lunstad, Smith, & Layton, 2010) drawing papers from more than a century (1900-2007) found that people with adequate - rather than poor or insufficient - social relationships had a 50% greater likelihood of survival regardless of follow-up period (the average was 7.5 years) and regardless of age, sex, initial health status, and cause of death. Where the type of social integration measure used was more complex than a mere binary indicator of residential status, the effect was greater, so the true magnitude of the effect is likely even higher than the overall finding. The researchers demonstrated the potential importance of the effect relative to other recognised causes of mortality (smoking, excessive alcohol consumption, obesity and lack of physical activity) with a startling bar graph showing social isolation dramatically outstripping all of the others, though with slightly overlapping confidence intervals. They noted research demonstrating the medical benefits of social relationships, namely, improved patient care, increased compliance with medical regimens, and decreased length of hospitalisation.

Holt-Lunstad and colleagues (2010) considered two main lines of theory explaining the role that social support may have in sustaining physical health. Social support is thought to (1) buffer against the effects of stress on health by providing informational, tangible and emotional support and (2) indirectly encourage healthy behaviours through cognitive, emotional, behavioural and biological influences that are not explicitly intended as support, e.g. the modelling of health behaviours, and the provision of a social set wherein compliance to healthy behaviour patterns and self-care are norms. Their finding suggests that a more important area for GPs to ask patients about than diet, exercise, or smoking is who they live with, and how supportive and emotionally expressive those relationships are.

Older men can be especially vulnerable when they lack adequate social support. This has been recognised in reviews of men's health literature (Courtenay, 2002; McKinley, 2005): lack of social support is associated with mortality and men have smaller social networks, fewer and less intimate friendships, are less likely to have a confidant (especially someone other than their spouse) and mobilise less varied support in times of stress. Courtenay goes so far as to suggest that most men may have no close friends other than their spouse. Indeed, this was borne out in the Australian study of 'mateship' mentioned earlier (Butera, 2008), and has also been shown in a population based Swedish study (Helgason, Dickman, Adolfsson, & Steineck, 2001) which compared male prostate cancer patients with men in the general population and found that both suffered the same threats of isolation: more than one in five had no-one in whom to confide their emotional concerns; of those who lived with a partner, seven in 10 confided in their partner only, and only one in 10 reported confiding in anyone else; of those who did not have a partner, nearly seven in 10 had no one to confide in. The study also found that men who had no one to confide in were less likely to report feeling alert and strong, calm, energetic, and happy, and more likely to report feeling depressed, sad, tired and worn out. An Israeli study of colorectal cancer survivors (Goldzweig et al., 2009) also found that unmarried men were significantly more poorly adjusted (worse depression, intrusive anxious thoughts, anxious preoccupation, and helplessness) than women or married men.

A review of gender and social networks later in life (Scott & Wenger, 1995) found that men are likely to have smaller informal networks since theirs are based on work or leisure activities which fall away with age and the deterioration of health. Men then become more dependent on networks generated and maintained by their wife and on their children and neighbourhood, whereas women's friendships are more associated with life stages and are therefore less affected by ageing and retirement. Men tend not to replace lost friendships, whereas women continue to make them throughout their lives. Their friendships tend to continue to focus around shared activities and socialising.

Health professionals have been urged to take special note of gender and marital status (Goldzweig, et al., 2009) and to expect that unmarried patients may be suffering higher distress. Attention should be given to their sources of social support and how the patient can take effective advantage of them. It has been recognised also that a special effort may be required to tailor social support services to the needs of male patients and to connect men to them (Helgason, et al., 2001). In New Zealand there are opportunities for men who are

older, somewhat disabled by illness, and consequently socially isolated to make new friendships through service clubs, support groups (e.g. men's groups run by the Cancer Society), the new Menz Sheds movement, and volunteer roles in the community. Community workers such as Cancer Society fieldworkers and Māori Cancer Coordinators can offer invaluable services in connecting men with opportunities that would suit them.

*What men want: Tips from men with cancer*

In the quotations below, note that 'I' means interviewer, 'P' means participant, '( )' signifies an encouraging but otherwise insignificant comment by the interviewer (e.g. 'Right', or 'OK'), and '[.....]' indicates that a chunk of text has been removed. The pseudonym and some personal particulars relating to the participant are at the beginning of each passage.

***Tip 1: Assume men know 'bugger all' about their health***

Men were asked, 'What did you know about cancer before diagnosis?' Most knew little. Some had learned through experience amongst their family or friends or picked up something through promotions by celebrities in the media (e.g. Paul Holmes telling about his prostate cancer), but very few had learned from educational leaflets and the like. Some seemed not to even have a vocabulary for symptoms, much less realise the potential significance of them. This has vital implications for engaging men productively as part of your medical practice: (1) Explain basic matters about how health and disease work (e.g. that cancer is about multiplying cells, not about contagious bacteria); and (2) Prompt men as to what health changes are significant to tell you (e.g. don't ask, 'Is everything alright?' but be specific: 'Do you need to go to the toilet during the night? How often?' etc.). .... and note that these needs may be exacerbated for men who have had little education and for Māori men.

*Freddie, Pākehā, 82 yrs, has little voice due to his advanced lung cancer:*

- I: Can you tell me Freddie what did you ... ummm... tell me about what you knew about cancer before you were ever diagnosed?
- P: Bugger all!
- I: [Laughs.] OK. So you didn't know any risk factors... what, sort of what to do, what not to do, to avoid cancer?
- P: [Points to tobacco pouch.]
- I: You knew about the old tobacco there? Freddie's just showing me his bag of tobacco there.
- P: I still smoke. ( ) I'm not going to stop. Its too late.
- I: Yeah, yeah. But you knew about that?
- P: Yes.
- I: OK.... So where did you learn about the smoking risk from?

P: From off the packet. [Indicates tobacco pouch.]

I: Just off the packet. Right. OK. OK. Had you seen any of the Cancer Society's leaflets or anything like that?

P: No

*Hank, Pākeha, 66 yrs, advanced prostate cancer:*

P: I knew a little bit about, well, prostate cancer particularly because I did have two uncles that had it, so I knew to look out for trouble with your bladder and that sort of thing. I didn't know a real lot about it, but ahhh... had done a little bit of reading about it. I wasn't aware of it because it didn't think it affected me at the time, but I did know what symptoms probably to look out for...( ) and I didn't look out very well.

I: Right, so, ... when you say 'you did a bit of reading'... ahmm, what material was that, do you remember - was that like Cancer Society material or...

P: No... it was probably just ahh... general newspapers and that...articles ( ) ...articles to make.... trying to make people aware of it, yeah.

I: So had you ever talked to any cancer survivors? You mentioned your uncle, uncles?

P: Yeah, I talked to them but not, not in great depth. Just, you know, talked to see how they were feeling and how they were handling it and that. ( ) Nothing... no great depth.

*Buck, Māori, 65yrs, prostate cancer:*

I: And, tell me, what did you know about cancer at the time?

P: That it kills you. That you're dead. ( ) There is no cure. ( ) That you... there is no cure - you're dead.

I: Right. Ok. And, and where did you get that impression from?

P: Um. Deaths of family members ( ) going down the female line on my mum's side. ( ) Yeah. Especially the first generation are all since dead.

I: Right, so, like, breast cancer and things like that, or...?

P: Yeah.

[....]

I: And so, what? [Your GP] took bloods and ticked the PSA box and...?

P: Yeah, that's right. ( ) Mmmm.

- I: So now you mentioned the nurse talking to you about that. What? Did she give you a ring, or something, afterwards, or something? About your PSA reading?
- P: No, no, no. ( ) Well, I was there. ( ) No, she... I, um... the bloods came back ( ) and she looked up on the computer ( ) and ah, she said to me, well she, she remarked, ( ) 'Oh, your PSA level's elevated' ( ) And, 'They're quite elevated'. ( ) I was in the dark what 'PSA levels' meant. ( ) I did, don't know what she was talking about. She could have ( ) been talking about, 'Ok, there's something wrong with my toe'. ( ) She said, 'You'd better get that checked.' ( ) 'You'd better, you'd better have a, you know, ah, get that sorted.... sorted, ah, make an appointment with your, a specialist in hospital.' ( ) Umm. I never went.
- I: Right. Did you actually have an appointment?
- P: No. Yes, I had an appointment. ( ) And that was for the PSA le-... By this time... I know now ( ) that um, yeah, this is, you know, ( ) this could be cancer.
- I: Yeah, but at that time you didn't?
- P: No. No.
- I: Yeah. So she got you - what? - a specialist appointment with the urologist or somebody? Like, up in [city]?
- P: Yeah. Yeah. ( ) That's right. And, ah, and I never turned up. ( ) I didn't want to go. ( ) Didn't want to know about it.
- I: Right. Because you didn't have a clue what it was about...
- P: Yeah.
- I: and you had other things to do.
- P: Yeah. That's it.
- I: Is that basically it?
- P: Yeah. ( ) Then it came back again. I went back and [.....] doctor kept asking me, 'Have you... Did you go have that test on your PSA levels?' ( ) I said, 'Ohhh'. He said, 'You never, did you? I'm going to make you another one, and you better go. See, this could be serious.' That's when I found out ( ) that, and the only times when I found out this could be cancerous.
- I: Right. That's when he told you.
- P: Yeah. ( ) That's reason why I was getting these done. ( ) Yeah.
- I: So that's - when? - so that might have been, sort of, 18 months later or something by then? When you saw the

P: Yes.

I: specialist?

P: Yes.

[.....]

P: We got in there [diagnostic consultation with urologist] and the doctor says, 'What are you shaking for?' I knew, I knew what was coming. You know... its the fear of the unknown. ( ) Of, ah, 'Have you got it? Haven't got it? If you haven't got it, what is it?' ( ) Um. I was thinking a whole lot of negative stuff, anyway. He came to me, and I'm shaking, and he, and he said to me, um, 'What are you shaking for? There's nothing to be... afraid.' You know. And then he s-, then he turned to me sister-in-law [his main support person], and said 'Yeah, he's, he's got cancer of the prostate.' ( ) Yeah. And I just sort of... then goes to me... the world's collapsed around... ( ) Because no... Pre-, preconditioned, years before: Cancer is 'finish'. That's it.

I: Yeah, that was what you believed.

P: Of course.

I: Yeah. Yeah. And, and you see this is, this is again where it's really important to hear that from you because, because particularly with Māori, they, they've got that recollection of it, you know, in their family. And, and so, that, that is exactly what happens. You know, but it, but the thing is, the treatment's been improving all the time, eh?

P: Yeah, and we're not to know that. We're ( ) we're... we don't mean to be ignorant of the fact that the medicine is ( ) improving. ( ) We don't mean... some of us are going through hard times, and ( ) we've got a living to make. ( ) So we're out of the loop in a lot of ways ( ) - not because we want to be, because of the necessity of other things ( ) that's going on in our lives.

*Richard, Māori, 52 yrs, limited literacy, prostate cancer:*

I: So even like, before they told you what the treatment involved... Like, you've been diagnosed, you know there's going to be some big changes, you don't know what they are,

P: No.

I: but you fear they're going to be something to do with the sex life and stuff?

P: Yes. Yeah.

I: Um. So even at that point, there was quite a big impact on your [intimate] relationship?

- P: Yes.
- I: Right, ok. And so what was the impact at that point?
- P: Well, because I, I was... blood come out... I was too scared to go towards her. ( ) I just didn't want to go there.
- I: Right. And is that, and is that...? Ah, well, what was the specific reason for that? What...?
- P: Well I was... thought I
- I: What were you worried about?
- P: I could possibly pass something on to her. ( ) I didn't want to kill her in any way. ( ) We might not be seeing eye to eye, but that was not ( ) my intention to her.
- I: Right. Ok. Yeah. Ok. So, so you were afraid that maybe you could
- P: Pass on.
- I: infect something?
- P: Yes.

***Tip 2: Make your advice relevant to men's lives***

Many men are tightly focussed on the challenges of their work and family responsibilities, and don't feel they have the time for vague warnings about things that may or may not go wrong with their health one day. Many also have a sense of invulnerability, having had very little personal contact with the health system all their lives (e.g. some of the men in this sample had never been to hospital before except to visit someone else – and they were of retirement age) so symptoms can get to crisis stage before they present for medical help.

To catch their attention, you need to tune-in to what is important to men - work and family responsibilities - and use metaphors that are meaningful to them, such as the WOF. For example: 'As you get older, the old motor starts to suffer a bit of wear and tear. From now on, I'd like you to come in once a year for a Warrant of Fitness. You don't want to break down on a bridge, eh? Shall I ask our staff to send you a reminder?'.

*Charlie, Pākeha, 70 yrs, advanced lung cancer:*

- I: In terms of any risk factors: the, sort of, smoking, sun care, that kind of thing....
- P: Yeah.
- I: Had you heard about all of that?

P: I knew. But it was never going to happen to me. ( ) I had duty free cigarettes, ( ) finest malt scotch, and...

I: Right. So where did you know about that from? [.....]

P: Know about the risks I was taking? ( ) Every-, my partner, you know, everyone said, 'Stop'. ( ) I didn't. ( ) So I can't blame anyone.

[.....]

P: I kept away from doctors, basically. ( ) 'Flu jabs each year - that was it.

I: Right. Ok. So you weren't one of these people who has a regular annual check-up or anything?

P: No. Only as part of the 'flu jab, and he'd say, 'Everything alright?' And I'd say, 'Yep, yep.'

[.....]

I: So in terms of getting along towards getting diagnosed yourself...

P: Mmhmm.

I: how did the issue first arise?

P: At [my sports ground]. I was becoming very breathless. [Charlie had collapsed and was hardly able to walk.]

I: Right.

P: And I saw my GP, [name], who did a blood test and sent me a letter, which I've retained I think, saying, 'No. Everything's fine.' And I think he also arranged, though, for me to have a... [calls wife from next room]. [Wife,] my love, at one point, you had to take me up to the hospital, didn't you, because I'd collapsed, or I'd...

Wife: Is this leading up to his diagnosis, is it? [.....] He saw the, the GP, his doctor. And he just gave him a general clearance and that, but he was still you know, breathless, and he was getting very weak, and I could see he was not, was very sick, and I said, 'Go back to him, and ask for x-rays and other stuff.' Anyway, so he, he went back. He had a blood test, which was clear. And he had an x-ray and was told to go back again. But while we were waiting for that, I see he was deteriorating. The appointment, again, with the doctor, was still weeks away. And so I, I asked [name] his brother, 'Could we just go please to the hospital to the emergency'. And that was after he had the second set of x-rays, and the CT scan. ( ) So, we went up to the emergency there, and the doctors who came in to see him, you know, were told that we were waiting for the CT and

P: Which I - excuse me - which I'd had earlier in the week.



Wife: Yeah.

P: And the emerg-, A&E doctors accessed that and said, you know, 'You're stuffed' basically. ( ) [.....] Cos it all happened very quickly. I could hardly breathe - I was falling over in the shower - all sorts of things.

I: Ok. So you... when you say, you 'saw your GP', you actually initiated the visit especially

P: Yes.

I: because of the breathlessness?

P: Yes. ( ) Yes.

I: Um. But he basically sent you away saying 'there's no problem'?

P: He didn't pick it up. No.

[.....]

Wife: You know, I mean, they say that you only have 90, 95% of the lungs was out of use.

I: Whew!

P: Mmm, it was bad! I...

Wife: Yeah, he was near

P: I couldn't walk -

Wife: death.

*Hank, Pākeha, 66 yrs, advanced prostate cancer:*

I: So what raised your initial concerns that you might have cancer?

P: Ahhh... probably a couple of things. One was having trouble urinating; one was urgency when I did; ( ) and the other one that I was getting quite swollen in my groin.

I: So just having raised that concern with yourself, ahhm, how how did that, ahhh, cause you to feel at the time? Do you remember?

P: Ahhh... no, it... I was just a little bit concerned. But for a little while I did nothing about it because I thought, 'Oh, it will get better', 'I can handle it', you know, 'I will overcome anything'. Ahhh... eventually I told my wife about my problems with ahh, my bladder ( ) and then we decided to have a check ( ).

I: So what prompted you to tell her, do you know?

- P: Ahhh ... because a couple of times there I was in such a rush for the loo I didn't quite make it ( ). I was getting a bit worried about wetting my pants,( ) so to speak.
- I: Oh right. So it was obvious that you had to say something?
- P: Mmmm.
- I: So you discussed together, you said you 'discussed it together and we decided to have a check'
- P: Yep - straight away. Yeah.
- I: Right, so that was ( ) so that was ahhm, that was a joint thing, or was it her suggestion or ...
- P: Ahhh ... it was her suggestion but I would've...yeah it was a joint thing.
- I: You were getting there...
- P: Yeah - I knew I had to do something - check it - because ( ) if it wasn't that, it was something else.
- I: Ummm, so factors that delayed your initial taking of action between when you first started to wonder and when you finally made that decision: What were those sort of factors that were just causing you to hesitate?
- P: One was I thought that, 'This won't ... I'm too strong for this... This won't happen to me', and then probably towards the last week or so I was probably thinking... I was probably a bit hesitant to go because I knew what it might be.

***Tip 3: Women can be very persuasive!***

Wives, daughters and other women (ex-wife, sister-in-law, friend... even service providers: female oncologist, Māori Cancer Controller, radiation therapist) played vital roles in connecting men with needed treatment and other services. They persuaded or prompted men to consult the GP, to take their treatments, to try alternative treatments, and to generally accept health-promoting assistance. They organised medications at home and supervised treatment compliance. They also connected men with needed services (e.g. transport to treatment, the Māori Cancer Controller). Quite frequently, they successfully pressured their men into taking a health-promoting action that he would not otherwise have taken. If you are concerned that you cannot persuade your male patient to take a prudent and important health-promoting action, the answer might be to engage some woman-power!

*Roger, Pākeha, 74 yrs, blood-injection-injury phobic, prostate cancer:*

- P: [My GP would] phone me up and say, 'You need, um....' - or the receptionist -

'You're due for a blood test', you know. So that sort of thing. [.....] Oh, I th-, he was watching the PSA.

I: Oh, because he was watching it?

P: Yeah, cos he, he'd been watching that for some time, and he'd been very, um, indecisive regarding the ( ) biopsy. ( ) But then in the end - [GP] hadn't actually quit, but he'd slowed down a lot - and we ( ) started seeing Dr [new GP] ( ) and she was more insistent. And with her, and [wife] together, it made it a bit more difficult...

I: To avoid! (laughs)

P: Yeah. [.....]

I: Right. So tell me a bit more about how you were feeling about that... you know, how were you feeling about it as you were noticing... as you were being told that your PSA was gradually rising? And then finally when you were told you must have a biopsy?

P: I was never worried about it. It's... I think because I never got anything... up till that I wouldn't ... you know. ( ) Um. So, I, I really didn't think I needed to have it done. ( ) Um. So I very much gave in to, um, pressure! (both laugh)

I: Right! So it wasn't really your, your idea [to have the biopsy]?

P: No.

I: It was, it was just to, to get the girls off your back?

P: Yeah.

I: Would that be fair comment?

P: Yeah. Well, my wife's really very good, and she was, um, she was really concerned and, and everything, and mainly I had it, had it done for her.

*Boxer, Pākeha, 76 yrs, prostate cancer:*

P: My daughter happened to see a TV programme about this guy who had intensive vitamin C treatment for swine flu.

I: Yeah, he was on death's door, wasn't he?

P: He was on death's door and ( ) so she said, 'Oh I think you should do that.' And she made the booking for me. ( ) She rang up of her own volition and organised it. She said, 'Ok, you, you're going in to see this woman for an interview.' And, ah, I said, 'Oh, thanks very much for that!' (laughs) But I went along with it.

*Paul, Māori, 56 yrs, bowel cancer with stoma:*

- P: So I've been doing treatment for about the last fi-, nine months, eh? (looking to caregiver – a female acquaintance who moved in of her own volition to help him through treatment) ( ) But it's working, though. Yeah.
- I: Yeah, yeah, yeah. You're looking good, I have to say.
- P: Yeah, yeah. Well I was down to something, 60-something kilos. Thanks to her, and looking after me, and giving me the right medication.... ( ) and.... Because, I wasn't listening before to people, so, but now, she's, 'If you don't listen to me, well I'm leaving.' So....
- I: So 'get your act together!' (both laugh)
- P: So 'take your pills' and 'take the food that I've left here for you' and, you know. [.....] Cos without her... because, you know, two o'clock in the morning, and four.... Because I had to take pills four times a day, and if you didn't take them.... ( ) And you're just here by yourself.... You got me mates... well they only wake up, you know... But she woke up at exactly two o'clock, four o'clock, six o'clock. [.....] She's helped, and without her cooking and looking after me, I don't think I'd be in this condition.
- I: Yeah. You know, you're looking good, eh?
- P: Yeah, that's what even the doctor said: 'Whatever you're doing, I don't know what you're doing, but keep it up!' (both laugh)

*Mike, Pākehā, 72 yrs, prostate cancer:*

- I: And how would you need to hear about [a counselling service]? Would you need to have a reference from somebody?
- P: Oh, somebody would need to... as far as I'm concerned, someone like a surgeon or a radiologist, or even, even the.... is a woman nurse, senior nurses in the radiology, ( ) who... the fact that they see you every day [he had a 39 treatment course of radiation], you, you get a - not necessarily attracted, and I don't mean wrong attraction - ( ) but you, you approve of what they do and how they do it. And they if they said to you, to me, 'I think, I'd suggest we, ah, make an appointment' - and they'd have to make an appointment ( ) - 'an appointment with, um, da da da. ( ) Um. And what day would suit you?' and gave no option. ( )(little laugh) I would probably do it.
- I: Right. So what about... now let, let's say that your little sortie with depression had lasted a bit longer,

- P: Brraaahhh!
- I: and say, let us say that somebody in a position like that had picked it up. Um. Is that what... you know, in a situation like that, could you see yourself speaking to somebody?
- P: (Whistles softly)
- I: If they said, 'Now look, what you need to do is talk to somebody like this [a counsellor], because you're not the first bloke with cancer that's ever been through something like this....'
- P: (Chuckles.) Ahhh...
- I: '...and I want you to, and I want you to talk to one of these people. I'm going to make you an appointment' - that's what you just said.
- P: Yes! Yes! (laughing) You'd have to lead them down the garden path! Otherwise I wouldn't do it. ( ) Oh, no, no - I'd, I'd be horrified. But at the same time, the same time I'm logic enough, logical enough to know that something has to happen. ( ) Yes, that depression thing - oh, boy! I don't know how some people cope with it.

***Tip 4: Give men information, warmth, and control***

Men appreciated being given the treatment options and implications and allowed to make their own choices. They liked to be talked to as an equal, but also appreciated personal encouragement and recognition of strength. A few were both inclined to and capable of making extremely effective use of information about their disease to seek out helpful (even critically important) further options using the internet or a second opinion. Men did not mind when their doctor told them the treatment option he or she preferred, but felt disrespected and could become uncooperative if they felt they were being told what to do. This effect was mitigated if the patient felt that his doctor was deeply and warmly concerned about him, but heightened if his doctor projected an expert-but-distant manner.

*David, Pākeha, 79 yrs, fearful of any medical or surgical intervention, prostate cancer:*

- I: But with [urologist], um...
- P: He was a cold fish.
- I: A 'cold fish'? Mmm.
- P: He, ah - probably very expert, expertise in his job, or very knowledgeable and all that - but he just told you, ah, 'That's your prostate and it's not right. And this is what can

be done: it can be cut out.' And, ah, 'What do you want to do about it?' (direct, flat, tone, spoken quickly) ( ) was the attitude.

[.....]

I: But he referred you on to

P: No.

I: [radiation oncologist] or [other radiation oncologist] or ..?

P: No, he didn't.

I: What did he do?

P: He just left it at that. So I came back and saw my doctor, [GP], here, ( ) and, ah, he said, 'Well you know, if it starts getting worse, we'll have to do something about it.' And that's when I rang my daughter, [name]. She [knew] Mr and Mrs [name] who came from [nearby town]. They used to have a hotel down at the beach. ( ) Motel. Motel. ( ) And he, he went to Australia to have it in those days. And he went because of the advice of [radiation oncologist]. ( ) So I rang up on the phone, and had a talk with his wife, and a talk with him. And he said you know, it's, ah, as far as he was concerned, he was out chopping wood that day, you know, and he'd only finished this treatment a month, or something like that. ( ) So that, what, ah... So I said, 'Could I get in touch with that doctor [radiation oncologist]?' And ah, he said, 'Yeah. She's in [city] hospital. You could ring her up or something.' So I sent her a letter. ( ) And ah, because [my GP] said, 'Oh, well, you've got the advice of, ah, you know, [urologist] and ( ) the [other urologist] and all that. Ah, I don't know whether [radiation oncologist] will want to have anything, you know, to do with it.' But ah, ah, and he wasn't... So that's why I went and wrote the letter. ( ) And she said, 'Come and see me.' (little laugh)

I: Wow!

P: Yes.

I: Well, you see, that's terrific! I mean, this is an interesting story.

P: Is that right? (laughs)

I: Well it is, actually, because that's not your typical route through the system!

[.....]

P: Mr [name], yeah - Mr [urologist], and he ah, and he said, 'You, ah... the right thing to do would be to have surgery and have it taken away' you see. That was a big shock, too. And on reflection now - that was away seven years ago - well I've had seven years of good quality life. ( ) Now my son's wife, [name], her father lives in [city] and he had surgery at that time. And he wears a nappy and sheath and all these sorts of

things. ( ) And that sort of thing. (little laugh) And that was one of the things that influenced me in, against that, you know. ( ) And I'm so glad that I didn't listen to Mr [urologist].

[.....]

I: What are some of those skills [people skills that the radiation oncologist had], as, that you perceive to be actually skills... Like, in a sense, is she a 'sales rep' for cancer care? (laughs) [David used to be a sales rep]

P: (little laugh) Well, the approach to a person coming in, walking in to a, a store and selling something... I used to feel that I had the best product of that type of thing, and the more I could sell to them, the bigger, ah... the bigger favour I was doing them. ( ) And that was the reason I was selling it. Well I think this same is, like, as I say, some ah, surgeons or doctors, sit and just tell you what can be done, and how he will do it and this sort of thing. Whereas people like [radiation oncologist], she, ah, she treats you as a... as a separate individual. ( ) The other ones treat you like, 'Next please', you know? ( ) 'This is what we tell you. Next please. This is what...'. ( ) She, she's not a bit like that. ( ) She's like, 'Right! (claps and rubs his hands together) What are we going to do?' You know?

I: Right. What are 'we' going to do?

P: Yeah: 'we'.

*Richard, Māori, 52 yrs, prostate cancer with stoma surgery for spread to the bladder:*

I: [Your urologist and surgeon] were pretty straight, but they were...

P: Not pointing fingers, but saying that ( ) 'Be aware that ( ) if you don't do this, you... She's all over, mate! See you later!'

I: So they were also quite straight but friendly as well.

P: Yes. Yes. There was no, no mincing anything ( ) and there was no feeling sorry for you and trying to make it easier on you... Just, 'This is how it is - you do it or you, you don't do it. Either way...', um...

I: 'It's up to you. '

P: Yeah. [.....] But a bigger, oh, possibly the biggest part of this is that, ah.... there are people that are really genuine about what goes down, eh? ( ) And if you can find those people ( ) it's probably lucky. You know?

I: So that's the single most important thing?

- P: Yeah. ( ) Yeah. Because when, when... yeah. Yeah. I don't know why we are like this, but that whakamaa is like... it comes up a lot in Māori. We are like that. When, when we... 'Oh! It's alright!' You know, we, we, we still tend to push things off like that, you know. Like, ( ) 'Don't worry about it, mate!'
- I: Just because you're not quite certain about it?
- P: Yeah. Yeah. ( ) Or, or understand anything. ( ) It's more easier to go, 'Oh, don't worry about it', or... ( ) than it is to... ( ) put the forward, put the foot forward and say, 'Oh yeah. It is me that wants the help.' ( ) But um we always get that: 'Oh, no don't worry about it', you know?
- I: Yeah. Yeah. Sort of, reticence, sort of thing. Sort of, withdrawing, sort of thing.
- P: Yeah.
- I: Yeah. Ok. Ok. But the, but the antidote is the right person. That sort of genuine person?
- P: It seems like that is...
- I: That is the answer.
- P: Yeah. Like before I met these two doctors, it was the same thing. I didn't know them from a bar of soap. But ( ) because they weren't, like... They were probably pushy, I don't, but it didn't feel like that. It didn't feel like that. ( ) They just gave the thing that they wanted to help. ( ) Mmm. And it wasn't pointing fingers or ( ) 'What you should have done', and ... ( ) they didn't do any of that, they just....

*Colin, Pākeha, 58 yrs, breast cancer:*

- P: I found dealing with him - my surgeon - I was very well informed ( ) and had a real good relationship with him straight away. ( ) He, and, and... And the day he diagnosed me, on that 5<sup>th</sup> November, he said, 'I, I've only known you for three or four weeks,' he said, 'but I know that you're going to be one of the ones that will get up and fight it, and you keep...you've got the right...'. He said, 'I see people, when I give them this diagnosis' - he was quite honest, eh - ( ) he said, 'I see people, when I give them this diagnosis, across the thing, and they get up and they walk out that door and I say, 'They're not going to make it.' He said, 'I feel that with your attitude, and with what I've seen in two or three weeks, that you'll be as good as gold. And I think we got it at a good stage.' He was very positive and I found that I had a real good re-... I'd only know him for three or four weeks - you know, like you have with doctors, and people like that ( ) - for three weeks. And you find some of the ones I've, not all of them, but some of the ones you deal with, very hard, some of them, to have a rapport with. But, no, I found him to be... straight away a real good rapport with him.



- I: Yeah. Can you put your finger on what actually built that rapport so well? Because that's an important thing to know.
- P: I, well I didn't ask a lot of questions, but I... he told me a lot of stuff that I wanted to know, kind of thing. You know. I, ( ) I went in there, I didn't have a big list of questions to ask, and my head was going around google-de-goo and that, but he was very... what he explained to me about why he wanted to get it done straight away, and, and... because I got in with him, he's pri-, he doesn't operate at the hospital in [city] so I didn't have a waiting list or anything - he took me in there, I was in there within ten days. ( ) But he just had a rapport with people. You know how you meet people and straight away you, you know... I suss people out pretty good after I've met them for a while. ( ) He had a good rapport with people straight away. ( ) Some people you can just hit it off with. But I found... and his mannerism was very good: ( ) 'Young man. Come here, young man.' And he goes to all the old ladies that are there, the ladies there, he puts out... 'Come in here, darling.' ( ) He just, you know, he's a hard case. [.....] And he gave all this to me simply Heather - he didn't, kind of, do all the jargon and everything. He, he laid it down to me... and that's what I appreciated, you know?

***Tip 5: Men want it straight... but not blunt***

Universally the research participants wanted doctors to 'be straight' with them. (This has already been alluded to in quotations above.) However, they didn't want delivery of bad news to be blunt. Ideally, they wanted an explanation of the diagnostic evidence leading to their diagnosis, then a clear statement of their diagnosis, and then a full explanation and unpressured choice of treatments, supported by take-home written material to remind them of what was said and perhaps provide more detail, all in a context of human warmth. Māori also noted that they did not want to be judged as neglectful, but that they appreciated sincerity, warmth and honesty very much – these qualities overcame any initial cultural diffidence.

It was disturbing to me that a large proportion of this sample of men ( $n = 11$ ; 40%) did not have a clear understanding of their disease status. In most of these cases I could tell from their treatment and monitoring protocols that their disease was more serious than they understood. Sometimes it seemed likely that a man was 'hearing only what he wanted to hear'. However, there was evidence of misleading, or simply unclear, advice. Obviously, a clear understanding of the disease status (prognosis, purpose of treatment) is necessary as a basis for making decisions about treatment, and also about other priorities in one's life. Information gives control, and although it can be distressing initially, in the longer term it is an antidote to anxiety.

*Buck, Māori, 65 yrs, prostate cancer:*

P: My support person, who has been with me all this time, my sister-in-law, asked [the oncologist] bluntly, 'Are you telling us that now he has, has not got cancer? But he will be on Zoladex [hormone cancer treatment] injections?' And the answer came back as affirmative.

*Harry, Pākeha, 76, prostate cancer, had been in surgery for incontinence when opportunistic biopsies were taken:*

P: But um, no, it was quite strange. When I went up there and they told me I had it, it was um, a slot in between the specialist's procedures, and he said, 'You've got this cancer, and we'll have to start thinking about what to do about it', and 'Cheerio. Goodbye.' And I sort of wandered out and um, the nurse came along and said 'Who's driving you home?' and I said, 'I drove myself over'. And 'Have you been given any booklets?' 'No. Nothing like that'. And she got some booklets to give me, and ah, and at that stage I, I was sort of wandering out of the hospital with a few pamphlets and, ah, 'You've got an aggressive prostate cancer.'

*Brucie, Pākeha, 55 yrs, prostate cancer:*

P: That, that particular day [the urologist] was, he was late for his appointment, he came in he was, he was, he had obviously been up at the hospital. And he was late for the appointment, he came screaming in the front door, slung his back pack on the floor, sat us down and said, 'Right, well, you've got cancer. Um. We're going to have to cut it out'. ( ) Um, and we went (indicates falling backwards) staggered back in shock. And we did... that meeting raised more questions than it gave answers. We'd... it was... and I take it that the other specialist is much the same - they're very, um, they're busy people - there are only two of them, and they don't have time to be pleasant - for the niceties, and break it gently. It's very very blunt, very, um, 'You should know all about it'. Kind of, 'You know you've got cancer, so you should have done some research and know all about it'. [.....]

I: What would you have preferred? How would you have preferred that to have been communicated to you?

P: (Pause, he strums his fingers on the table for a few seconds while thinking.) Um, I, I my preference I think, would be... I'm an information person. I know everybody does things differently - takes them in differently - I, I thrive on information: facts and figures and processes. ( ) Um, and I would have just, my personal preference would have been to actually have, to have someone sit down with me and just go a bit slower. Spend...

I: Right, so go over the PSA this, and scan that, and...

- P: Yeah. Yeah. And, I mean, he just, well he did, did the ultrasound, did the digital, and he didn't actually say a thing. ( ) Just sat me down and says, 'Yep, you've got cancer. ( ) Next time we meet, we'll be in surgery'.
- I: Really?! Mmm. OK. But we weren't?
- P: No. Next time we met was actually the biopsy.
- I: So what happened?
- P: Ah, no, I think he was getting a wee bit carried away. (sigh)
- I: I think he might have had a day of it, somehow. He was just, he was dropping the ball.
- P: Yeah, yeah. Yeah. I suspect that too. And, and we walked away from there going, 'Cor, blimey!' Just sat in the car in the car park for a while just trying to digest it all, you know. (Pause)
- I: Mmm. (Pause.) 'Is this happening?'
- P: Mmm. Mmm. 'Whose nightmare are we in?'

*Tama, Māori, 59 yrs, acute myeloid leukemia:*

- I: And can you remember how... how much of the... exactly what, what [the haematologist] said? Can you remember?
- P: 'I won't treat you if you don't want me to. ( ) If you wish to die, that's up to you. ( ) But this is what I can offer you.' [.....] Because I asked to be straight. ( ) Don't, don't get that wrong: When I first saw him, I said, 'No matter how bad it may... ( ) you tell me the truth.' I looked him right in the eyes. ( ) 'You tell me the truth no matter what.' And he looked at me and he goes, 'I will not lie.' ( ) And I knew, ( ) 'You're honest.'

[.....]

- P: And I went in and saw him [a monitoring consultation after treatment]. And just before I left he said, 'Get a blood test, eh? Before you go and catch the shuttle home.' So he gave me this sheet of paper and ( ) ticks off what... ( ) So I went. I went and got the blood test. That evening he called me and said, 'Sorry, [name], it's come back.'

*Monty, Māori, 75 yrs, prostate cancer:*

- P: And was um, well it was quite distressing - what actually happened - that day ( ) because his, ah, understudy, or whatever you call it

- I: Was it a 'registrar' or something?
- P: 'Registrar'. Yeah. ( ) He was explaining to us the operation and what they would do ( ) and how long I'd be in hospital, and ( ) and um, and then he said,... you know, he didn't even have all the papers there, and he said, 'Oh, have you had a bone scan?' And I said, 'Yeah, I've had the two scans'. 'Oh,' he said, 'hang on. I'll better go and get the... find them.' ( ) And um, he said, 'Mr [urologist] should be just about finished now.' Anyway, they both came back together. And, er, he read the, ah, scan results ( ) and said something, and ah, [urologist] said, 'Oh, there was never any, er, likelihood of an operation. ( ) It's, ah, too far advanced' he said. 'There's no way we can operate', he said, ah, 'That is out of the question.' Um, he said, ah, 'Sooner or later,' he said, 'it will catch up with you and kill you' he says, ah, 'so go away and have a good time.' ( ) Yeah. Just like that. Yeah. ( ) So. It was... you know.
- I: Well there's a lesson in how not to do it.
- P: Yeah! My, my daughter was there - she burst into tears, and.... yes. You know, after explaining about the operation, and what they'd do, and how it would affect me, and... (unclear word) thinking I'm going to have an operation. Hmmm. But anyway... So that was that.

***Tip 6: Take – and make – your opportunities***

The most common reason for men in my sample presenting late for diagnosis was that they failed to recognise a symptom. The most common reason for early diagnosis was detection of a symptom by a GP at a regular or administrative check-up, or whilst monitoring another condition. The message for GPs is clear: promote regular general check-ups and take advantage of every presentation by a man to check for important indicators (e.g. PSA levels). And every such opportunity to educate men about symptoms is worth grasping: be sure you talk them through all the symptoms you are checking every time you have their captive attention!

*Rodney, Pākeha, 59 yrs, prostate cancer:*

- P: I'd read up about it. ( ) I knew the symptoms to look out for. ( ) But I never had any symptoms.
- I: Right. Ok. Ok. Well now, tell me about, tell me the story about how you got diagnosed, then?
- P: Oh. I've just, I've got another sickness: I've, I have sleep apnoea. ( ) And um - going back for some years - and I was, I'd been under treatment, and I'd been to the doctor. And I go every three months ( ) to get a certificate - sickness - and I said oh, I just told her once, I said, 'I still go to sleep'. She said, 'I'll give you a full health check-up'.

And that's when she picked it up. It must, she must have put it on the form to do my blood,

I: What? PSA blood test?

P: have my PSA done, at the same time.

I: Right. Ok. So it was just a general check that she was doing?

P: Yeah, well yeah, but also I'd done a... the nurse had taken me through, last, like a health thing, from the family.

I: Right. 'Family history'.

P: A family history was part of it. And I think I'd mentioned there that one of the grandparents had it. ( ) But not that I knew what it was back in those days, but....

I: No, no. Still, that's good that you were able to alert them to that though, eh?

P: So I think that's when they looked for it.

I: Right. Ok. So, so what transpired, do you know? How did they...? They, they sent away that PSA test?

P: Mmm.

I: And then what happened?

P: Um. Got back and they said, 'Oh, well, your PSA is quite high'. ( ) And explained what it was, and what, ( ) what, 'We're going to send you to a specialist' - check up on it.

*Eddy, Pākeha, 74 yrs, prostate cancer:*

I: So what did raise your initial concerns that you might have cancer?

P: Ummm, the doctor. ( ) He, he, umm, ...about six months before he said I probably had cancer, I had a PSA reading of about 5, and six months later it was 26. And he said, 'You've got to see a specialist'. So I went.

I: OK. So was he... you know... how did he come to be taking those PSA readings?

P: He, he usually asks for a blood test once a year.

### ***Tip 7: Make health accessible***

Many men work rigid hours. Services that recognise this are valued.

*Colin, Pākeha, 58 yrs, breast cancer:*

- P: Yeah. And he would see me any time of the day. Like, you know, he's, he's a real busy man, he's got that... he said, 'Any time'... after I had surgery and that, and ( ) that's a bit of follow-up, and we'll get that later, but he would see me any time - I'd just walk into the surgery. ( ) You know, I needed time to go in - he used to see you off the...
- I: Right, now that's interesting too. I'll be interested for you to tell me more about that, because that's an important one with men, because, you know, a lot of a lot of men have got some pretty rigid hours and it's not easy for them.
- P: No, no, but he was really flexible ( ) and he said, 'You come in here any time after five o'clock - I'll see you any time.' You know, he was.... And the other thing that freaked me out... oh sorry... it was, I got my first two bills and it was nearly \$700 ( ) for my first... cos he's a private thing. ( ) And I said to him, I said, 'Look,' I said to him after three or four - and I paid them, paid them, I was a bit short of cash then, and my sister actually lent me \$1000 just to get them paid out, so I wanted to pay - I said, 'Look [surgeon], I'm a solo dad, I have got a bonus', I said, 'I've got hospital cover to get my operation done...', ( ) and, you know, since that day, he's never charged me a cent. ( ) And I found that really good. He, well, he made quite, you know, he did alright out of the operation - it was four and a half thousand dollars for the operation, or something, at the private hospital - ( ) but he did a, but he's never ever.... And I've always asked the nurse, I... 'No. [Surgeon] said there's no charge.'

*Mike, Pākeha, 72 yrs, prostate cancer:*

- P: Ah, when the health nurse that checked the guys at work said, 'Your PSA's coming up', ( ) that's when I went to the doctor.
- I: Ok. So that was a regular check done by the nurse at work?
- P: Yeah, once a year.
- I: And she noticed the pattern of increase?
- P: Yeah.

***Tip 8: Take his presentation seriously***

Eight of the 27 men in my sample had delayed diagnosis due to GP failure to recognise the importance of symptoms or due to delays in the system. The GP failures constituted serious oversights in the face of obvious symptoms (e.g. blood in urine, collapse due to breathlessness). On the other hand, some health professionals went to lengths to have

worrying symptoms addressed appropriately, much to the gratitude of their patients. Most men trusted their doctor's opinion and followed his or her advice without obtaining a second opinion or doing further research, so it is important that that advice is the best it can be.

*Peter, Pākeha, 52 yrs, advanced renal cell cancer:*

P: How I was diagnosed? Ok. I just had a, sort of, palpitations in my heart, and I was feeling a bit stressey, or a bit funny, and I'd wake up at night and sort of sit up in bed, because it was, um, I thought I was going to flake out or something. Thought perhaps I'd better go to the doctor and see ( ) what's going on here. ( ) So I went and saw the doctor - had to wait in the emergency queue at the (little laugh)... Um, it's a bit of an issue here actually - the GP situation. ( ) And the nurse that I was with, took my blood pressure and everything, and she wanted to know the story, so I told her what my problem was, and she was all worried about it. And I went and saw the GP and he explained to me that everyone gets palpitations, and what you really need to do is put your nose in a paper bag and breathe deeply and it will go away and you'll be ok. And so I thought, 'Oh. Ok.' And then the nurse appeared at the door with a wheelchair - she was going to take me across to the clinic.

I: (laughs) That's a bit of divergence of opinion on that one!

P: Yeah. And this doctor sort of, um, hummed and haa-ed about it and said, 'Oh, ok. Take him across there for a check - check his heart out', I think. ( ) And she put me on to the, on to the wheelchair and explained to me that the wheelchair was essential because, oh, I would be in a queue too long at the ( ) A&E (interviewer laughs) and that's part of the plan to jump the queue.

I: Oh, well done!

P: So ( ) we got over there, and they checked it out, and didn't find much wrong with my heart. But then they decided they were going to do an x-ray, and they did an x-ray, and found there were some growths in the media-sternum. [.....] And... so they didn't know what it was exactly, they just knew it was, it looked like cancer - explained it as that. The next problem was... They wanted me to have a CT scan ( ) and to get it, and to get a biopsy on this, the lungs, you see. ( ) And so they thought well perhaps they'd admit me into the [rural town] hospital, because that would help to get it done quicker. (little laugh from interviewer) Otherwise, if you're on the, if you're an outpatient, it takes longer to get in there and they thought it would be quite good ( ) to get in there and get it sorted as quick as they could. So they got me in for that.

### ***Tip 9: Take advantage of being Māori***

To my concern, all six of the Māori men in my sample were single, and all but one were in the lowest income category. Two were wary of being judged negatively by health professionals, apparently from bitter experience. Two had limited literacy, and all but one suffered considerable ignorance of health facts. However, most had one very strong advantage: the support of their whanau and, especially, their mokopuna. The strength and health benefit that this provided was not always recognised by health professionals, however.

*Buck, Māori, 65 yrs, prostate cancer:*

- P: My sister-in-law was a great help. She'd take me through this stuff. ( ) She's terminal, yeah.
- I: So she's learnt a lot through that? Is that, is that where she gets her knowledge from? Where does she get her knowledge from?
- P: She gets her knowledge through her condition and, and, and ( ) what she's going through. Chemo and stuff. ( ) And she's... but her knowledge is this, ah, 'That one will sack you now' - this is at the beginning - 'That doctor will sack you now, and you'll move on to this one.' (interviewer laughs) ( ) And she, you know, she'll take you through the stages of where you are ( ) and what will happen. The people, you'll meet. 'Now you're ready for this ( ) and that.' And I'll be like a child again - and ( ) and, and I was - ( ) because [sister-in-law] she had it over. Because I don't know: This is the first...
- I: Right. So, it's just in terms of explaining the whole process?
- P: Yeah.
- I: 'Now we do this, now we do that.'
- P: Yeah.
- I: So you know what's going on.
- P: Yeah. Like you can trace it back: step, step. You know, ( ) from the diagnosis ( ) to.... to what step we're going to take with you.
- I: Right. And this is where, this is where your sister-in-law can help?
- P: Yeah. This is this is where she did help ( ) - and a lot! Yeah. ( ) And she put me on to services such as the shuttle. ( ) And made sure... cos I was, ( ) cos I was ah, I went, 'Oh, no - I'll drive up.' 'No you won't!' And she'd do, she'd be there laying the law down.



*Richard, Māori, 52 yrs, prostate cancer, major stoma surgery for spread to the bladder, approached suicide twice but restrained himself for the sake of his mokopuna:*

- P: Well, we've always been tight, but since this has happened, um, my grandkids love being here, and I don't know who or how they see it, but ah, when they turn up it feels like this is our last day ( ) and we use it up! ( ) Mhmm. Mmm.
- I: So is that... do you think there's something that's changed in you, in your appreciation? As a... that's caused... that's part of that, or?
- P: Um yeah. Possibly, yeah. I mean, because they've warmed to me, I'm, I'm just warming back to them. (claps hands together)
- I: Yeah. Was that how it was before?
- P: Um, pretty much. But it just seemed to have gotten stronger, ( ) ah, since this happened. ( ) Mmm. [...] Even up to whether.... (little laugh) They were up the hospital, and the nurse comes in, and she gives me this little note. I read it, and, and it says on there, 'Can you please ask all your children not to be turning up all hours?' (both laugh) I thought it was cool! I framed it. Anyway, I've got it in my other, ah, space. (both laugh) ( ) Mmm. ( ) But it'd make all the other... I mean, my kids are pretty open, and they can, they can talk about things. ( ) But um, there's three other people in the ward, in my ward at home, and there was no problem for my kids go and talk to them, to the other patients in the ward, and
- I: yeah. Lovely, eh?
- P: yeah. ( ) It was just when they started jumping on the bed! [...] Yeah. They smuggle all the lollies in, and...
- [...]
- P: But I was not a very happy fella. That (little laugh) second time round.
- I: For real! No. So what, what sort of.... um, when you say you were 'not happy', we're mostly talking about pain here?
- P: Yeah.
- I: Actual physical pain?
- P: Yes. Yes.
- I: Right.
- P: Because um, my stomach was so tight, it was like this. But I, I, I couldn't pass wind, I couldn't go to the toilet, I couldn't do nothing, it was agony. ( ) You know. Eventually they stuck a thing down my throat and
- I: Right. Got it out that way.

- P: It all came out that way. Mmmm. ( ) That wasn't very flash, so...( ) In the end, look in the bag that you just spewed up out of your mouth, and it's, it's crap! It's like you just bitten into... ( ) But, ah. [.....]
- I: Ok. Ok. Gee, you really went through it the hard way, didn't you?
- P: Mmm.
- I: Ok. So, how did you cope with all of that?
- P: Hard. Ah, but.. the... probably the kids again.
- I: Yeah. And they were coming up pretty regularly?
- P: Yeah. All the time. ( ) Up to... really, the, the notes were sort of regularly coming from the nurses by this time, to.... 'not as many kids up at once!' (both laugh)
- I: Yeah. So they kept you going?
- P: Mmmm.

***Tip 10: Correct misconceptions about psycho-social services***

Most of the men in my sample had a poor image of counselling and men's support groups. However, they often also admitted knowing little about how such services worked and were open to persuasion. The majority also said that they would prefer a referral or recommendation from their doctor to connect them with a counsellor. Dr Don Baken is a practicing psycho-oncologist seeing patients from the MidCentral DHB. He finds that both men and women relate well to the concept of 'mental health skills coaching' in the face of an exceptional stressor (cancer treatment or life threat). We would like to encourage use of the term 'coaching' rather than counselling, and also for doctors to recommend patients connect with their local Cancer Society and/or Māori Cancer Coordinator service. Note that these services also provide useful practical supports (like transport, or help with WINZ), which are particularly important for low income men.

*Buck, Māori, 65 yrs, prostate cancer:*

- I: How do you think it would go down with Māori men, in general - not that you can really generalise about people, but - if, um, if, you know, if [the Māori Cancer Coordinator] was given details of people and rung them up as they, as they sort of, after they were diagnosed and something? And sort of said, 'Hey! Here I am.'
- P: They'd love that. It's a voice over the phone that cares. ( ) And, and yeah. And she... I've, I've got, I've, you know, she's got this way of... '...and we'll touch base.' There's a, there's a key word. ( ) 'And we'll touch base', instead of, 'Oh, I'm coming round to see you' - it sounds so impersonal. [.....] It's not invasive.

Richard, Māori, 52 yrs, prostate cancer:

- P: I like [the Māori Cancer Co-ordinator] ( ) and I think she's pretty much straight from the hip shooter, ( ) and she don't mix or mince her words ( ) or anything like that to make you feel good. ( ) I think I... if I had seen her at the start then I think a lot of these things that were offered [counselling when he felt suicidal], I probably would have went and done ( ) because I think [the Māori Cancer Co-ordinator] would have helped me to, 'Come on now - let's just go down there'. Like when, when my appointments with WINZ and... ( ) which I really don't want to go and do, and... ( ) But in her two minutes with a cup of tea, and... 'Alright! That's us! Let's go down and see what we can do.'... and, and that made me go there, you know. (laughs)( ) Well, but if, because I didn't have that push from anybody....
- I: Yeah, just to get, get you past...get you over the, sort of, whakamaa barrier.
- P: Yes. ( ) Yeah. Ok. ( ) And again... and again, you're sort of saying that it came down to her sort of personality?
- I: Yes. That she, um, wasn't pointing no fingers and, and, she was offering ( ) help and...mmm.

### References

- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking *American Psychologist*, 58(1), 5-14.
- Axelrod, S. D. (2001). The vital relationship between work and masculinity: A psychoanalytic perspective. *Psychology of Men & Masculinity*, 2(2), 117-123.
- Brannon, R., & Juni, S. (1984). A scale for measuring attitudes about masculinity. *Psychological Documents*, 14(1), University microfilms no. 2612.
- Burke, R. J. (2002). Men, masculinity, and health. In D. L. Nelson & R. J. Burke (Eds.), *Gender and Health* (pp. 35-54). Washington, DC: American Psychological Association.
- Butera, K. J. (2008). 'Neo-mateship' in the 21st century: Changes in the performance of Australian masculinity. *Journal of Sociology*, 44(3), 265-281.
- Courtenay, W. (2005). Counseling men in medical settings. In G. E. Good & G. R. Brooks (Eds.), *The new handbook of psychotherapy and counseling with men* (pp. 29-53). San Francisco: Jossey-Bass.
- Courtenay, W. H. (2002). Behavioral factors associated with disease, injury, and death among men: Evidence and implications for prevention. *International Journal of Men's Health*, 1(3), 281-342.
- Courtenay, W. H. (2003). Key Determinants of the health and well-being of men and boys. *International Journal of Men's Health*, 2(1), 1-30.
- David, D. S., & Brannon, R. (1976). The male sex role: Our culture's blueprint of manhood, and what it's done for us lately. In D. S. David & R. Brannon (Eds.), *The forty-nine percent majority: The male sex role* (pp. 1-45). Reading, MA: Addison-Wesley Publishing Company.

- Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, 49(6), pp.
- Goldzweig, G., Andritsch, E., Hubert, A., Walach, N., Perry, S., Brenner, B., et al. (2009). How relevant is marital status and gender variables in coping with colorectal cancer? A sample of middle-aged and older cancer survivors. *Psycho-Oncology*, 18(8), 866-874.
- Good, G. E., & Brooks, G. R. (2005). Introduction. In G. E. Good & G. R. Brooks (Eds.), *The new handbook of psychotherapy and counseling with men*. San Francisco: Jossey-Bass.
- Helgason, A. R., Dickman, P. W., Adolfsson, J., & Steineck, G. (2001). Emotional isolation: prevalence and the effect on well-being among 50-80-year-old prostate cancer patients *Scandinavian Journal of Urology & Nephrology*, 35(2), 97-101.
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *Plos Medicine / Public Library Of Science*, 7(7), e1000316.
- McKinlay, E., McBain, L., Kljakovic, M., De Silva, K., Lambie, L., & McLeod, D. (2005). The men's health project. Wellington: Otago Medical School.
- McKinley, E. (2005). Men and Health: A Literature review. Wellington: Wellington School of Medicine and Health Sciences, University of Otago. Retrieved September 2010 from <http://www.wnmeds.ac.nz/academic/gp/research/2005NHCeditedmenshealthlitreview.pdf>.
- Mitchell, D., & Horn, A. (2006). Men's health: The OHN view. *Safeguard*, 97, 16.
- Sabo, D. (2005). The study of masculinities and men's health. In R. W. Connell, J. Hearn & M. S. Kimmel (Eds.), *Handbook of studies on men & masculinities* (pp. 326-352). Thousand Oaks: Sage Publications.
- Scott, & Wenger. (1995). Gender and social support networks in later life. In S. Arber & J. Ginn (Eds.), *Connecting gender and ageing: A sociological approach* (pp. 158-172). Philadelphia: Open University Press.
- Stanton, A. L., & Courtenay, W. (2004). Gender, stress, and health. In R. H. Rozensky, N. G. Johnson, C. D. Goodheart & W. R. Hammond (Eds.), *Psychology builds a healthy world: Opportunities for research and practice* (pp. 105-135). Washington D.C.: American Psychological Association.
- Thompson, E. H., & Pleck, J. H. (1986). The structure of male role norms. *American Behavioral Scientist*, 29(5), 531-543.
- White, A. (2001). How men respond to illness. *Men's Health Journal*, 1(1), 18-19.